

BRAIN INJURY SOCIAL HISTORY

Instructions: This information is necessary for a complete assessment, so that the right services can be provided. Please answer all questions as completely as possible.

IDENTIFYING INFORMATION:

1. Name: _____ Age: _____ Race: _____

Birth date: _____ Soc. Sec. #: _____ Sex: _____

Drivers License #: _____

Current Day and/or Residential Placement: _____

Home Address: _____ Home Phone: _____

Medicaid # (if applicable): _____

Any medical diagnosis (if known): _____

Any mental health diagnosis (if known): _____

Normal pregnancy/delivery? Yes ___ No ___ If no, please explain _____

How and when did injury occur?

PRESENTING PROBLEM:

2. What are your present emotional, behavioral, or medical problems, or problems that led to this referral? _____

What is being done about this problem? _____

3. Do you live alone or with others? If you live with someone, who do you live with?

(Please include relationship.)

4. Have there been any major family incidents or tragedies (death, divorce, rape, imprisonment, etc.), which may have affected you? If so explain and tell when:

FAMILY HISTORY:

5. Father's Name: _____ Age: _____ Race: _____

Birth date: _____ Deceased: _____ If so, date: _____

Cause of death: _____

List any medical, mental health, or substance abuse family history, if any, of father or father's family:

6. Mother's Name: _____ Age: _____ Race: _____

Birth date: _____ Deceased: _____ If so, date: _____

Cause of death: _____

List any medical, mental health, or substance abuse family history, if any, of mother or mother's family: _____

7. Brothers and sisters:

Name	Birth date	Sex	Medical/Mental Health

8. Spouse's Name: _____ Age: _____ Race: _____

Birth date: _____ Deceased: _____ If so, date: _____

Cause of death: _____

List any medical, mental health, or substance abuse family history, if any, of spouse or
spouse's family: _____

9. What skills did you have to relearn after injury? _____

10. Are vaccinations current?

PRE-BRAIN INJURY:

11. Check any of the characteristics listed below, which applied to you as a child growing up:

	Shy or timid		Very active, into things more than others
	Withdrawn		Sleep disorder
	Bed wetting		Restless
	Cry easily or often		Often hit, hurt, or was aggressive towards other children
	Excessive anger, rage		Unusual fears
	More interested in things than people		Rocking
	Daredevil behaviors		Head banging
	Less active		Strange thoughts
	Fought constantly		Difficult to control
	Excitable, impulsive		Destructive
	Quarrelsome		Disliked being touched
	Distractible, poor attention span		Loner
	Problems making and keeping friends		Feelings easily hurt
	Denied mistakes and blamed others		Basically an unhappy child
	Passive		Stole things from others
	Cruel to pets or animals		Often injured self

12. Have you had previous emotional illness, which required treatment? If so, briefly describe problems and symptoms, location, and date of treatment: _____

13. Have you ever been arrested? If so, briefly describe charge, circumstances, what happened, and dates. Have you been in jail or prison? _____

MEDICAL HISTORY:

14. List any major illnesses, injuries, convulsions, etc., and age these took place: _____

List lifetime history of hospitalizations:

Reason for Hospitalization	Date	Location

15. Have you had any vision problems? _____ If so, were glasses prescribed? _____
If so, when? _____ Date of last vision check: _____
16. Do you have a known hearing loss? _____ When was hearing last check? _____
17. Have you had problems with alcohol or drug dependence? Briefly describe: _____

EMERGENCY CONTACTS:

Physician:		Phone:	
Address:			
Dentist:		Phone:	
Address:			
Responsible Party:		Phone:	
Address:			
Guardian/ Conservator		Phone	
Address:			

EDUCATIONAL HISTORY:

18. At what age did you begin school? _____
19. How many grades were completed? _____
20. Were any grades repeated? If so, why? _____
21. Which grades, if any, involved special education? _____

22. Highest grade achieved?

Degrees or Diploma	Date

VOCATIONAL HISTORY:

23. List all past:

Vocational Placements or Employment	Date

24. Have you had work related problems? _____ Reliable? _____

Special skills or success?

Problems with employers or other employees? _____ Explain: _____

PRESENT STATUS:

25. List current medications:

Type	Amount	Reason Prescribed	By Whom

26. List any other special behavioral problems: _____

27. List any allergies: _____

SELF HELP SKILLS

28. Check appropriate boxes:

Services/Help	Yes	No	Needs No Help or Supervision	Needs Some Help or Supervision	Needs More Help or Supervision	Needs Total Help and Supervision
Do you receive help with:						
Personal Care Assistance (Bathing, dressing, getting out of bed, toileting, and eating)						
Housekeeping (Laundry, cleaning, meals, etc.)						
Transportation						
Shopping/Errands						
Personal Finances (Money management)						
Services from Health Professional (RN, Therapist, etc.)						
Adult Day Care						
Home Delivered Meals (Formal Only)						
Any Other Kind of Help						

29. If help is needed, who provides assistance? _____

30. If that person is unavailable, is there a backup? _____

CURRENT SOCIAL ADJUSTMENT

31. Do you have friends? (Few? Any at all? A leader? A follower? Takes part freely in social activities? Lead a lonely life? Prefer older or younger friends? Seek or avoid opposite sex?) Briefly describe? _____

Form completed by: _____

Relationship to applicant: _____

Date: _____